**CONSENT TO TREAT**

**Client Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to diagnostic evaluations and clinical treatment to be provided for myself, my child, and my family by

***PATRICIA M. WILKINS-VACCA, LCSWR***

504 Haight Avenue

Poughkeepsie, NY 12603

(845) 527-9456

Treatment may include individual therapy, family therapy, group therapy, and parent guidance. I understand and agree that as part of treatment, my familys and my participation may be required.

I also realize that sometimes treatment may result in a short term, temporary increase in previous problems or the appearance of new problems before things improve. I also realize that any behavioral change in a person or family results in both positive and negative consequences (gains and losses). I expect my therapist to help me understand and plan for this as part of treatment.

Client’s signature (Parent/Guardian ,if child) Relationship to client

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Witness/Therapist Date